DOCUMENT RESUME

ED 306 719 EC 212 782

AUTHOR Barack, Robin S.; Gable, Robert A.
TITLE Return to the Mainstream: Reintegration of Behavior Disordered Adolescents into the Public Education System.
PUB DATE Sep 86
NOTE 23p.; Paper presented at the National Adolescent Conference on Programming for the Developmental Needs of Adolescents with Behavior Disorders (Minneapolis, MN, September, 1986).
PUB TYPE Reports - Research/Technical (143)

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS *Adjustment (to Environment); Adolescents; Aggression; *Behavior Disorders; Clinical Diagnosis; Depression (Psychology); Followup Studies; *Mainstreaming; Normalization (Handicapped); *Outcomes of Treatment; Program Effectiveness; Psychiatric Hospitals; *Student Adjustment; Student Placement

ABSTRACT

The study sought to assess adolescents' school functioning following discharge from short-term placement in a psychiatric hospital. Follow-up data were obtained on 46 students (ages 13-18) discharged during a 6-month period. Conduct disorder (socialized aggressive) and major depression were the most frequent diagnoses. Questionnaire data results showed that 56% of students did not attend the educational program recommended by the treatment team during hospitalization. Although multiple stages of educational intervention were advocated, the majority of behavior disordered youth were excluded from many settings. Among other trends noted were the mobility of the population, greater female stability in educational placement, and the fact that the majority of students were judged to be functioning successfully in their post-discharge school placements. Cited as recommendations are the development of a peer-referenced set of guidelines for determining treatment goals, a functional criterion against which to measure the impact of treatment, and a social referent or standard by which to determine post-treatment adjustment. (JW)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

ED306719

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)
☑ This document has been reproduced as received from the person or organization originating it.
☐ Minor changes have been made to improve reproduction quality.
• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

Return to the Mainstream: Reintegration of Behavior Disordered Adolescents into the Public Education System[1]

Robin S. Barack, Ph.D.
Clinical Psychologist
Pittsburgh, PA

Robert A. Gable, Ph.D.
Associate Professor
Old Dominion University

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY
Robert A Gable
TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

Running Head: MAINSTREAM

[1]Address Correspondence to Dr. Robert A. Gable, Associate Professor, Child Study and Special Education, Child Study Center, Old Dominion University, Norfolk, VA 23529

EC 212782

BEST COPY AVAILABLE

Return to the Mainstream: Reintegration of Behavior Disordered Adolescents into the Public Education System

Over a decade ago, enactment of Public Law 94-142 mandated an appropriate educational program for all handicapped students. That legislation called for providing instruction as close to the regular education setting as is feasible (Federal Registrar, 1977). The concept of "least restrictive environment"--commonly referred to as mainstreaming, has led to significant changes in service options for the handicapped. Even so, for children and youth classified as behavior disordered it is often likely that agencies outside of the public education system will still provide services (Leone, 1984). As in the past, reliance is often on private and out-of-district placement rather than on programs within regular education settings (Grosenick, 1981). Although current policy encourages placement in less restrictive environments, inpatient psychiatric care remains a necessary alternative for certain moderately to severely behavior disordered children and youth (Gable & Strain, 1979). By most accounts, these youngsters pose problems so extreme that neither the public school, the family, nor the community are capable of providing the needed services.

Since a substantial number of adolescent's psychiatric disorders are school-related, it seems reasonable to view decisions regarding hospitalization not only from a psychiatric but also an educational perspective. As originally proposed by

Deno (1970), the cascade of services model provides a mechanism by which to assess a disturbed youngster's need for educational services. The cascade model assumes that the educational enterprise is "one vast social system" which is constantly involved in making judgments regarding the student's academic achievement and behavioral acceptability. Deno (1970) proposed a system of seven levels of educational intervention -- from least to most restrictive. This continuum of services generally corresponds with a range of behavior problems encountered in the schools; that is, the more severe the problem(s), the more likely it will be that treatment is provided outside the mainstream of public instruction (Kerr & Nelson, 1983). In that hospitalization is predicted on the existence of a psychiatric disorder it follows that admission is linked to psychiatric (DSM III) rather than educational classification. However, review of available literature supports the fact that the relationship between the cascade model and decisions regarding psychiatric intervention is essentially unknown.

There is widespread recognition that events which follow short-term psychiatric intervention play a pivotal role in determining the ultimate success of treatment (e.g., Gable, Hendrickson, Warren, Evans & Evans, in press; Lewis, 1982). Several studies have borne out the significance of educational placement following psychiatric hospitalization. For example, in a retrospective investigation of adolescents discharged from a psychiatric hospital, Bloom and Hopewell (1982) found that the

one factor that distinguished students who adjusted from those who did not evidence a satisfactory adjustment was school placement. Since educational placement is an important ingredient in post-treatment adjustment (Bloom & Hopewell, 1982), selecting an appropriate placement and facilitating a smooth transition seems critical to the maintenance of continuity-of-treatment. Yet, as Forness and Caldon (1980) asserted, post-discharge educational adjustment has rarely been considered because admission to a psychiatric hospital is generally not based on academic difficulties.

In all, most professionals concur that treatment of behavior disordered adolescents should be viewed along a continuum according to intensity of required interventions (e.g., Kerr, Nelson & Lambert, 1987). However, the extent to which current practices correspond to this perspective is essentially unknown. While it is reasonable to assume that the major criteria for psychiatric hospitalization is linked to DSM III, it is less certain what comparable standards are applied to decisions on post-treatment placement. Information on post-discharge placement and adjustment that might contribute to future placement decisions is virtually nonexistent. The purpose, therefore, of the present investigation was to examine: (a) the relationship between psychiatric and educational decisions regarding intensity of treatment, (b) the decision-making process regarding post-treatment education placement, and (c) placement outcome as validation of the appropriateness of placement decisions.

Method

Subjects and Setting

The subjects of the present study were adolescents discharged from a short-term psychiatric placement in a hospital situated in a large metropolitan area. Forty-eight students discharged during a 6-month period comprised the sample on which follow-up data were obtained. Selection of subjects was limited to students who had received liaison services, had signed release of information forms, and for whom an address of the school recommended for post-discharge placement was available.

Of the 129 patients receiving liaison services, 61 were female and 68 were male. Services ranged from a brief discussion with the classroom teacher to a multidisciplinary team meeting held at the student's school in addition to a meeting with the patient's family. Only school-aged students, from 13 through 18 years, who were involved in some way with the public or private school sector were included in the study. Excluded from the sample were students referred to a state hospital or a residential facility. In the sample there were 25 females and 23 males. The average age of the students in the follow-up sample was 15.4 years.

Insert Tables 1 & 2 About Here

According to DSM III classification, twenty-five percent of

the students were given a primary diagnosis of conduct disorder-socialized aggressive (312.23). Major depression was the next most frequently occurring category, with 5 of the 48 patients (10%) receiving this diagnosis. The diagnostic categories most often applied are presented in Table 1.

Procedures

Upon admission, signed releases of information forms are obtained and remain in effect for six months following discharge. During this period, there were forty-eight students for whom releases to the post-discharge educational settings were available. For purposes of data collection, a preliminary questionnaire was sent to each of the schools to which students were referred (see Table 2). The questionnaire surveyed current school placement and classroom performance of subjects. A total of 48 questionnaires were distributed of which thirty-seven were returned.

Of the eleven questionnaires which elicited no response from the school, phone information was obtained on nine students, five of whom were at the schools to which they had been referred. Fifteen questionnaires were returned completed and twenty-two returned uncompleted. These 22 students were not at the educational placement to which they had been referred. In sum, data was available on 46 patients (96%).

Insert Tables 3 & 4 About Here

Results

Questionnaire data on students discharged from psychiatric care showed that fifty-six percent of the students did not attend the educational program recommended by the treatment team during hospitalization (See Table 3). Examination of the data revealed that females appeared more likely to be provided services according to placement recommendations (see Table 3 & 4). Fourteen females (56%) were enrolled in the prescribed school placement. Of the eight female students not in the expected setting and for whom information on subsequent placement was available, five remained in the same type of class (e.g., regular class placement) but in a different school. These changes in placement were often linked to a change in living arrangements or a family move. The remaining female students went to a more restrictive setting than was recommended, (i.e. a residential treatment center). In contrast, only seven of the males (30%) were placed in the recommended educational program. Of the ten who went to a different program, none were in a regular class setting. Two were found to be full-time students in classes for the "socially and emotionally disturbed" within a separate school building, whereas two others went to a residential treatment center. Finally, three other students dropped out of school and three were placed in juvenile court shelters or youth development centers.

Of the twenty-two students with written responses indicating that the school who did not follow through on the recommendations,

a change in placement originally had been recommended for eight (37%). By comparison, no change in placement had been recommended for 14 students (64%). Ultimately, a different school placement occurred for twelve (55%) of these 22 students, while two (9%) dropped out of school. No further information was available on eight (37%) of the students' who did not attend recommended placements; forms were returned simply marked "not currently enrolled", with no further explanation.

Teacher Ratings on Classroom Behavior

Fifteen completed teacher questionnaires were returned on post-discharge classroom behavior. In one case, the student was no longer at the school and the questionnaire was completed based on pre-admission behavior. Consequently, usable follow-up information was obtained on 14 students, four males and ten females. A change in educational placement occurred for six students (43%) while eight students (57%) returned to the school they had attended prior to hospitalization. Receiving schools reported that the recommendations were appropriate 71% of the time and not appropriate 14% of the time. Fourteen percent of respondents stated that they had no knowledge regarding the appropriateness of recommendation (Table 5).

Insert Table 5 About Here

The results of the usable questionnaire data showed that

teachers generally checked "frequently" or "sometimes" for positive behaviors and "almost never" or "sometimes" for negative behaviors (i.e., student easily loses control). Overall, the majority of the students were judged to be functioning successfully in their school placements. Data revealed that almost twice as many females as males (56% vs. 30%) were found at the school to which they had been referred (see Table 4). Further information was unavailable on 26% of the males 12% of the female students studied.

Discussion

Deno (1970), Kerr and Nelson (1983), and Kerr, Nelson and Lambert (1987), have stressed that a hierarchy of educational services -- from least to most restrictive, is useful for making educational placement decisions for behaviorally disordered students. In practice, 68% of the students in the present study were admitted directly from a regular classroom to a psychiatric hospital, thereby bypassing the intervening steps within the cascade model (i.e., a resource room or a self-contained special class). As a result of hospitalization, a change in placement to a more restrictive setting followed for 49% of the students. Change in educational placement following psychiatric hospitalization has been reported elsewhere in the literature. Forness, Barnes, and Mordant (1983) reported that change in placement may be part of the "diagnostic role" of the psychiatric hospital within the educational system. Forness and his colleagues found that 62% of their sample (49 elementary and high

school-age students) changed educational classification as a result of psychiatric hospitalization. Although multiple stages of educational intervention have been advocated, results of the present study suggest that the majority of behavior disordered youth are excluded from many settings on that continuum. In addition, students skip over interim placements and leave a regular class to go to the most restrictive setting, i.e., a psychiatric hospital. The concept of least restrictive environment (Public Law 94-142) does not seem to be adhered to with severely behavior disordered adolescents.

The current study attempted to assess adolescents' school functioning (both academic and social) following discharge from a psychiatric hospital. Several trends noted were: (1) this population is very mobile, (2) females evidence more stability in educational placement, and (3) most students appear to make a good school adjustment when school placement recommendations are followed. Follow-up information obtained from the schools revealed that 56% of the female and 30% of the male students were at the school the release indicated they would be attending. Slightly more than half of the students were at different educational placements. Placements varied from students progressing from middle to high school to attending an intensive treatment unit of a residential facility rather than a resource room for socially and emotionally disturbed students. Female students evidenced more stability in their placement and were less likely to change either living arrangements or school

placement. If there was a change, it often was not more restrictive; rather it was to a similar placement in a different school. Although speculative, these findings may be attributable to a more tolerant view regarding disorders evidenced by female than male students.

Data were obtained on a relatively limited sample of students. However, assuming they are representative, findings suggest that most of the students were functioning adequately in school. For example, ninety percent were seen as having sufficient intellectual ability, and 58% frequently came prepared and were able to work productively in class. In terms of negative behavior, only 16% of the students were reported to frequently lose control but 37% were seen as being frequently disruptive.

Conclusions and Implications

Several issues have been raised regarding the dilemma of educational placement for behavior disordered adolescents following brief hospitalization. The significance of matching a pupil's learning and behavioral characteristics with service delivery systems available in the community has been discussed elsewhere (Hallahan & Kauffman, 1977). However, according to findings of the present and previous studies (Forness et al., 1983), it is apparent that a substantial number of adolescents move from a less to more restrictive setting as a function of psychiatric hospitalization. Further research should be conducted on what happens to these youth since it appears that for male

students, many never attend the recommended school placement. A second issue pertains to how professionals of various disciplines can enhance a youngster's adjustment to school both in the hospital and upon discharge. More extensive investigation needs to be conducted in the schools where the students are assigned to answer this question.

Current practices in psychiatric settings suggest that information on the impact of treatment geared toward enhancing a adolescent's learning and adjustment is available from several sources. Multidisciplinary assessment(s) usually is conducted by personnel representing the disciplines of psychiatry, psychology, neurology, special education and social work (Barack & Gable, 1984). Data are gathered through observation and completion of standardized questionnaires on such factors as: (a) conduct, (b) learning, and (c) social status. It follows that measures obtained across professional disciplines should serve as criteria for judging not only the positive influence of inpatient care, but also to determine the most appropriate post-treatment placement.

Available evidence indicates that most post-discharge placement decisions are predicted on unsupported opinion regarding the needs of the adolescent. In contrast, by accumulating indirect (i.e., questionnaire) and direct (i.e., observation) data on adolescents served by psychiatric facilities and similar information on comparison groups of so-called normal

youth in less restrictive settings (e.g., regular school classrooms) an empirical framework could be established for making several important decisions. Specifically, by aggregating data on adolescents receiving inpatient treatment and comparing it with information on their regular counterparts: (1) an empirical peer-referenced set of guidelines for determining treatment goals, (2) a functional criterion against which to measure the impact of treatment (i.e., changes in behavior), and, (3) a social referent or standard by which to determine post-treatment adjustment, would be established. The thrust of future investigation, therefore, should be, as previously suggested by Kazdin (1977), to create a direct measure of behavior that distinguishes (in selected settings) "adjusted from maladjusted" youth and yields tools complementary to conventional evaluation. Research should be directed toward generating an empirical basis -- to replace subjective evaluation -- for social validation of: (a) treatment goals and (b) treatment outcomes, and in turn, establishing a functional criterion against which to judge the effectiveness of post-treatment placement decisions (Cullinan, Epstein & Reimers, 1981). The treatment of adolescents' behavior disorders represents a complex and difficult undertaking. According to findings of the present and previous studies it seems clear that a multidisciplinary effort that is sensitive to community norms can be of greater benefit to adolescents requiring inpatient psychiatric care than more traditional practices.

References

Barack, R.S., & Gable, R.A. (1984). School liaison services following brief psychiatric hospitalization. Paper presented at the Conference on Programming for the Development Needs of Adolescents with Behavior Disorders, Pensacola, Florida.

Bloom, R., Hopewell, L. (1982). Psychiatric hospitalization of adolescents and successful mainstream reentry. Exceptional Children, 48, 352-357.

Cullinan, D., Epstein, M., & Reimers, C. (1981). Social validation: Evaluating the effectiveness of interventions with behaviorally disordered pupils. In F. Wood (Ed.). Perspectives for a new decade, pp. 63-71, Reston, VA: Council for Children with Behavior Disorders.

Deno, S. (1970). Special education as developmental capital. Exceptional Children, 229-257.

Federal Register, Vol. 42, No. 163 -- Tuesday, August 23, 1977.

Forness, S., Barnes, T.R., Mordant, J.M. (1983). Brief psychiatric hospitalization: A study of its effect on special education placement. In R. Rutherford (Ed.). Severe Behavior Disorders of Children and Youth, Vol. 6, pp.66-75. Reston, VA: Council for Children with Behavioral Disorders.

Forness, S., & Caldon, P. (1980). Subsequent school adjustment of children and adolescents discharged from a psychiatric hospital as a function of length of stay. Journal for

Special Educators, 17, 4-9.

Forness, S., Cronin, C., & Lewis, L. (1981). Prediction of post discharge school from social and academic gains made during hospitalization. In R. Rutherford, Jr., A. Prieto & J. McGlothlin (Eds.). Severe Behavior Disorders of Children and Youth, Vol. 4 pp. 70-77, Reston, VA: Council for Exceptional Children with Behavior Disorders.

Gable, R.A., Hendrickson, J.M., Warren, S., Evans, S.S., & Evans, W.H. (in press). The promise and pitfalls of an ecological perspective to behavior disorders. In R. Rutherford, Jr. (Ed.). Severe Behavior Disorders of Children and Youth. Reston, VA: Council for Children with Behavior Disorders.

Gable, R.A., & Strain, P. (1979). Staff training issues within residential programs for behavior disordered children. Behavioral Disorders, 4, 201-207.

Grosenick, J. (1981). Public school and mental health services to severely disturbed students. Behavioral Disorders, 6, 183.

Hallahan, D., & Kauffman, J.M. (1977). Categories labels, behavioral characteristics: ED, LD, and EMR reconsidered. Journal of Special Education, 11, 139-149.

Kazdin, A. (1977). Assessing the clinical or applied significance of behavior change through social validation. Behavior Modification, 1, 427-452.

Kerr, M.M., Nelson, C.M. & Lambert, D. (1987). Helping adolescents with learning and behavior problems. Columbus, OH: Merrill.

Kerr, M.M., & Nelson, C.M. (1983). Strategies for managing problem behavior in the classroom. Columbus, OH: Merrill.

Leone, P. (1984). Reconciling educational rights of handicapped pupils with school disciplinary code. In R. Rutherford & M. Nelson (Eds.). Severe Behavior Disorders of Children and Youth, Vol. 7, pp. 80-85, Reston, VA: Council for Children with Behavior Disorders.

Lewis, W.W. (1982). Ecological Factors in successful residential treatment Behavioral Disorders, 7, 149-156.

Table 1

Psychiatric Diagnosis of Behavior Disordered Adolescents

DSM III Diagnosis	Number	Percent
Conduct disorder - soc./aggressive	12	25
Major depression	5	10
Dysthymic disorder	4	8
Conduct disorder - undersoc./aggr.	4	8
Conduct disorder - social./non-aggr.	4	8
Oppositional disorder	3	6
Anorexia nervosa	3	6
Other (one for each diagnosis)	13	27

Table 2

Student's Name: _____

Date of Birth: _____
Grade: _____
School: _____

Type of Placement: _____ Reg. Class _____ EMR Class
_____ LD (resource room) _____ SED (resource room)
_____ LD (self-contained) _____ SED (self-contained)
_____ (approved Private School) (___ BI, ___ SED, ___LD)
_____ Residential Facility

Is the student currently enrolled: Yes _____ No _____
Did the student attend prior to hospitalization? Yes _____ No _____
Overall, do you feel referral to this type of educational placement was appropriate? Yes___ No ___
Why? _____
_____

PLEASE ANSWER THE FOLLOWING QUESTIONS REGARDING STUDENT:

	Frequently	Sometimes	Almost Never
1. Interactions with adults were generally appropriate.			
2. Interactions with peers were generally appropriate.			
3. The student is extremely withdrawn.			
4. The student's behavior is disruptive to other students.			
5. His/her intellectual ability seems sufficient for performing in this type of setting.			
6. The student has requisite academic skills to succeed.			
7. The student comes prepared and is able to work productively in class.			
8. The student loses control easily.			
9. The student completes assigned tasks.			
10. The student follows ruels and established classroom routines.			
11. Student waits for turn and participates at proper time in class.			
12. The student can use free-time appropriately.			
13. The student asks irrelevant questions.			
14. The student can concentrate on tasks and ignore distractions.			
15. The student is verbally aggressive (e.g., teases, threatens, others, calls out).			

Please add any additional information that you feel would be helpful regarding the future educational placement of the student. THANK YOU!

Comments: _____
_____
_____

Signature: _____

Table 3

Pre-and Post-Hospitalization Educational Placement of Behavior Disordered Adolescents

Educational Placement	Percent Admission	Discharge
Regular Class	68	35
Educable Mentally Retarded	6	2
Learning Disabled	5	4
S.E.D. (Resource or Self-Contained)	13	25
S.E.D. (Separate Facility)	5	12
Residential Treatment Center	2	18

There was a change in educational placement for 49.6% of the patients.

N = 129 students

Table 4

Post-discharge School Placement of Adolescents

	Males		Females	
School Placement	Number	Percent	Number	Percent
Where expected	7	30	14	56
At another program	10	43	8	32
No information available	6	26	3	12
	23	100	25	100

Table 5

Teacher Ratings of Classroom Behavior of Discharged Adolescent Patients

Question	Percent		
	Frequently	Sometimes	Almost Never
1. Interactions with adults were generally appropriate	61	38	--
2. Interactions with peers were generally appropriate	58	42	--
3. The student is extremely withdrawn	8	50	42
4. The student's behavior is disruptive to other students	37	7	56
5. His/her intellectual ability seems sufficient for performing in this type of setting	90	9	--
6. The student has requisite academic skills to succeed	75	25	--
7. The student comes prepared and is able to work productively in class	58	25	16
8. The student easily loses control	16	25	58
9. Student completes assigned tasks	50	50	--
10. Follows general rules and established classroom routines	58	33	8
11. Student waits for turn and participates at proper time in class	36	36	27
12. Can use free-time appropriately	33	33	33
13. Student asks irrelevant questions	25	16	58
14. Can concentrate on task, ignore distractions	43	33	25
15. Student is verbally aggressive (e.g., teases, threatens others)	33	--	67